Inpatient Hyperglycemia - Adult

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No history of diabetes

See Page 4

Type 2 diabetes or steroid induced diabetes/hyperglycemia

See Page 2

Type 1 diabetes or insulin pump or history of total pancreatectomy or history of DKA

Page Endocrinology-Diabetes for urgent consultation which requires clinician to clinician communication

INITIAL EVALUATION

Patient with known diabetes or blood glucose > 180 mg/dL

Does patient meet diagnostic criteria for hyperglycemic emergency?

Yes

See Hyperglycemic Emergency Management (DKA/EDKA/HHS) – Adult algorithm

No

Patient with known diabetes or blood glucose > 180 mg/dL

Check hemoglobin A1c if not completed within the last 3 months

Begin POC glucose monitoring

Note: Insulin dose adjustments should be made based on the individual patient’s glucose. Refer to the Hypoglycemia Management algorithm, as indicated.

PRESENTATION

TREATMENT

DKA = diabetic ketoacidosis
EDKA = euglycemic diabetic ketoacidosis
HHS = hyperosmolar hyperglycemic state
POC = point of care

1Hemoglobin A1c may be inaccurate if recent blood transfusion within the past three months or severe anemia

2Diagnostic criteria:

DKA: blood glucose > 250 mg/dL, arterial or venous pH < 7.3, bicarbonate < 15 mEq/L, beta hydroxybutyrate (BHB) > 3 mmol/L, osmolality < 320 mosm/kg

EDKA: blood glucose ≤ 250 mg/dL, arterial or venous pH < 7.3, bicarbonate < 15 mEq/L, BHB > 3 mmol/L, osmolality < 320 mosm/kg

[Note: Blood glucose may be lower than expected in patients on SGLT-2 inhibitors (e.g., canagliflozin, dapagliflozin, empagliflozin, ertugliflozin)]

DKA with HHS: blood glucose > 600 mg/dL, arterial or venous pH < 7.3, bicarbonate < 15 mEq/L, BHB > 3 mmol/L, osmolality ≥ 320 mosm/kg

HHS: blood glucose > 600 mg/dL, arterial or venous pH ≥ 7.3, bicarbonate ≥ 15 mEq/L, BHB ≤ 3 mmol/L, osmolality ≥ 320 mosm/kg

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Department of Clinical Effectiveness V5
Approved by the Executive Committee of the Medical Staff on 05/21/2024
Inpatient Hyperglycemia - Adult

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Note: Insulin dose adjustments should be made based on the individual patient's glucoses. Refer to the Hypoglycemia Management algorithm, as indicated.

**PRESENTATION**

Type 2 diabetes or steroid induced diabetes/hyperglycemia

- Stop high-risk home medications
- Hold metformin if eGFR < 45 mL/minute/1.73 m²

**ASSESSMENT**

Is patient on > 100 units of insulin daily or on Humulin U-500 insulin at home?

- Yes → Consult Endocrinology-Diabetes
- No → See Page 3

Does patient have risk factors for hyperglycemia or hypoglycemia?

- Yes → Initiate basal bolus insulin therapy at 0.4 units/kg/day subcutaneously with 50% of TDD used for prandial fixed bolus (lispro) dosing and 50% used for basal (glargine) dosing (see Appendix A and B)
- No → Assess insulin needs every 24 hours
  - Consider a no concentrated carbohydrate diet

**TREATMENT**

Are any glucose levels > 180 mg/dL after 48 hours?

- Yes → Consult General Internal Medicine (Consultative Medicine - Inpatient Consults) or Endocrinology-Diabetes
- No → Discharge planning:
  - Consider resuming home medications, as appropriate
  - Consider the following as clinically indicated:
    - For patients with hemoglobin A1c < 7.5%:
      - Follow up with treating physician, primary care physician, or endocrinologist
    - For patients with hemoglobin A1c 7.5-9%:
      - Consult Certified Diabetes Care and Education Specialist (Diabetes Educator)
      - Follow up with treating physician, primary care physician, or endocrinologist
    - For patients with hemoglobin A1c > 9% or new to insulin on discharge:
      - Consult Certified Diabetes Care and Education Specialist (Diabetes Educator)
      - Arrange ambulatory referral to Endocrinology-Diabetes

---

1 Hold home insulin and oral hypoglycemic agents such as sulfonylureas (e.g., glipizide, glyburide, glimepiride, gliclazide), meglitinides (e.g., repaglinide, nateglinide) and SGLT-2 inhibitors (e.g., canagliflozin, dapagliflozin, empagliflozin, ertugliflozin). Generally, metformin and DPP-4 inhibitors (e.g., sitagliptin, linagliptin, saxagliptin) are safe to continue if renal and liver function are stable.

2 Calculation of total daily insulin taken at home: add the total units of all long acting (glargine, degludec, or detemir), intermediate acting (NPH), and short acting (lispro, aspart, glulisine, or regular) insulin in a typical 24 hour period

3 Risk factors for hyperglycemia include: New enteral feedings or PN, Post-operative status, High dose steroids (see Page 3)

4 Risk factors for hypoglycemia include: Acute or chronic renal failure, Poor nutritional status or oral intake, Failure to thrive, NPO status for anticipated procedures

4 For critically ill patients, refer to IP Critical Care Glycemic Management order set; consider insulin infusion for 2 consecutive glucose levels > 200 mg/dL within 24 hours. Refer to Appendix C for transition from insulin infusion to basal bolus insulin therapy.
## New enteral feedings or PN with glucose level > 180 mg/dL
- Consider tube feeding formulas with lower carbohydrate count/higher fat content if appropriate for patient’s nutritional requirements
- Consider addition of regular insulin to PN based on dextrose content
- Consider Endocrinology-Diabetes consult

## Post-operative status
- Initiate Post-Operative Insulin Basal Bolus order set (see Appendix B)³
- Assess insulin needs every 24 hours
- If steroid use is anticipated on discharge, consider Endocrinology-Diabetes consult

## High risk for hypoglycemia: acute or chronic renal failure or failure to thrive
- Initiate basal insulin (glargine) at 0.15 units/kg/day subcutaneous and supplemental sliding scale bolus insulin (lispro) subcutaneous (see Appendix A and B)³
- Assess insulin needs every 24 hours

## High risk for hypoglycemia: poor nutritional status or oral intake, or NPO status for anticipated procedures
- Initiate basal insulin (glargine) at 0.2 units/kg/day subcutaneous and supplemental sliding scale bolus insulin (lispro) subcutaneous (see Appendix A and B)³
- Assess insulin needs every 24 hours

## High dose steroids²
- Initiate basal bolus insulin therapy at 0.6 units/kg/day subcutaneous with 60% of TDD used for prandial fixed bolus (lispro) dosing and 40% used for basal (glargine) dosing² (see Appendix A and B)³
- Assess insulin needs and steroid dosing every 24 hours
- If steroid use is anticipated on discharge, consider Endocrinology-Diabetes consult

Note: Insulin dose adjustments should be made based on the individual patient’s glucoses. Refer to the Hypoglycemia Management algorithm, as indicated.

### TYPE 2 DIABETES OR STEROID INDUCED DIABETES/HYPERGLYCEMIA

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Treatment</th>
<th>Evaluation</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>New enteral feedings or PN with glucose level &gt; 180 mg/dL</td>
<td>- Consider tube feeding formulas with lower carbohydrate count/higher fat content if appropriate for patient’s nutritional requirements</td>
<td>Are any glucose levels &gt; 180 mg/dL after 48 hours?</td>
<td>Consult Endocrinology-Diabetes</td>
</tr>
<tr>
<td>Post-operative status</td>
<td>- Initiate Post-Operative Insulin Basal Bolus order set (see Appendix B)³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk for hypoglycemia: acute or chronic renal failure or failure to thrive</td>
<td>- Initiate basal insulin (glargine) at 0.15 units/kg/day subcutaneous and supplemental sliding scale bolus insulin (lispro) subcutaneous (see Appendix A and B)³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk for hypoglycemia: poor nutritional status or oral intake, or NPO status for anticipated procedures</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>High dose steroids²</td>
<td>- Initiate basal bolus insulin therapy at 0.6 units/kg/day subcutaneous with 60% of TDD used for prandial fixed bolus (lispro) dosing and 40% used for basal (glargine) dosing² (see Appendix A and B)³</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Follow-Up
- Discharge planning:
  - Consider resuming home medications, as appropriate
  - Consider the following as clinically indicated:
    - For patients with hemoglobin A1c < 7.5%:
      - Follow up with treating physician, primary care physician, or endocrinologist
    - For patients with hemoglobin A1c 7.5-9%:
      - Consult Certified Diabetes Care and Education Specialist (Diabetes Educator)
      - Follow up with treating physician, primary care physician, or endocrinologist or arrange ambulatory referral to Consultative Medicine (General Internal Medicine)
    - For patients with hemoglobin A1c > 9% or new to insulin on discharge:
      - Consult Certified Diabetes Care and Education Specialist (Diabetes Educator)
      - Arrange ambulatory referral to Endocrinology-Diabetes

Note: Refer to Insulin Decision Support Tool to assist in placing orders (for internal use only)

1 For critically ill patients, refer to IP Critical Care Glycemic Management order set; consider insulin infusion for 2 consecutive glucose levels > 200 mg/dL within 24 hours. Refer to Appendix C for transition from insulin infusion to basal bolus insulin therapy.

2 High dose steroid therapy is considered to be ≥ 8 mg/day of dexamethasone, 50 mg/day of prednisone, 40 mg/day of methylprednisolone or 200 mg/day of hydrocortisone

3 In recurrent admissions for chemotherapy containing steroids, please review last Endocrinology-Diabetes note for more specific insulin dose recommendations and use as indicated

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**ASSESSMENT**

- **Are any glucose levels > 180 mg/dL after 48 hours?**
  - Yes
    - Consider initiation of basal bolus insulin therapy at 0.3 units/kg/day subcutaneous with 50% of TDD used for prandial fixed bolus (lispro) dosing and 50% used for basal (glargine) dosing (see Appendix A and B)
    - Assess insulin needs every 24 hours
  - No

- **Are there 2 consecutive glucose levels > 180 mg/dL within 24 hours?**
  - Yes
    - Consider basal bolus insulin therapy at 0.5 units/kg/day subcutaneous with 60% of TDD used for prandial fixed bolus (lispro) dosing and 40% used for basal (glargine) dosing (see Appendix A and B)
    - Assess insulin needs and steroid dosing every 24 hours
    - Consider a no concentrated carbohydrate diet
  - No

**TREATMENT**

- Consult Certified Diabetes Care and Education Specialist (Diabetes Educator)
- Consult Endocrinology-Diabetes

**PRESENTATION**

- **Is patient on high dose steroid therapy?**
  - Yes
    - Consider Adult Insulin Sliding Scale order set or Critical Care Glycemic Management order set² as indicated
    - If patient has received checkpoint inhibitors³ within the past year, consult Endocrinology-Diabetes
    - Assess insulin needs every 24 hours
  - No

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1 High dose steroid therapy is considered to be ≥ 8 mg of dexamethasone, 50 mg of prednisone, 40 mg of methylprednisolone or 200 mg of hydrocortisone per day
2 For critically ill patients, consider insulin infusion for 2 consecutive glucose levels > 200 mg/dL within 24 hours. Refer to Appendix C for transition from insulin infusion to basal bolus insulin therapy.
3 Checkpoint inhibitors: nivolumab, pembrolizumab, durvalumab, atezolizumab, and related drugs. Patients with recent exposure to checkpoint inhibitors are at risk for DKA and should be evaluated for new onset type 1 diabetes mellitus.
### APPENDIX A: Common Insulin Types and Frequency

<table>
<thead>
<tr>
<th>Fast Acting Insulin</th>
<th>Dose Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lispro (Humalog&lt;sup&gt;®&lt;/sup&gt; or Lyumjev&lt;sup&gt;®&lt;/sup&gt;)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Before meals or every 4 hours</td>
</tr>
<tr>
<td>Aspart (Novolog&lt;sup&gt;®&lt;/sup&gt; or Fiasp&lt;sup&gt;®&lt;/sup&gt;)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Before meals or every 4 hours</td>
</tr>
<tr>
<td>Glulisine (Apidra&lt;sup&gt;®&lt;/sup&gt;)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Before meals or every 4 hours</td>
</tr>
<tr>
<td>Regular insulin (Novolin&lt;sup&gt;®&lt;/sup&gt;-R/Humulin&lt;sup&gt;®&lt;/sup&gt;-R)</td>
<td>Before meals or every 6 hours</td>
</tr>
</tbody>
</table>

| Long Acting Insulin | | |
|---------------------|-----------------------------|
| Glargine (Lantus<sup>®</sup>/Basaglar<sup>®</sup>/Toujeo<sup>®</sup>/Semglee<sup>®</sup>)<sup>1</sup> | Daily or every 12 hours |
| Detemir (Levemir<sup>®</sup>)<sup>1</sup> | Daily or every 12 hours |
| Degludec (Tresiba<sup>®</sup>)<sup>1</sup> | Daily |

| Intermediate Acting Insulin | | |
|-----------------------------|-----------------------------|
| NPH (Novolin<sup>®</sup>-N/Humulin<sup>®</sup>-N) | Every 12 hours |

| Mixed Insulin | | |
|---------------|-----------------------------|
| 70/30, 75/25<sup>1</sup>, 50/50<sup>1</sup> (mixes of NPH and a fast acting insulin) | Every 12 hours or every 6 hours with continuous tube feedings |

<sup>1</sup> Not currently on MD Anderson Formulary

### APPENDIX B: Basal Bolus Insulin Terms

- **Bolus** insulin refers to a dose of fast acting insulin. This is typically comprised of *prandial* insulin which is scheduled to compensate for the carbohydrate content of a meal and *supplemental* (or sliding scale) insulin to correct hyperglycemia. Bolus insulin is most effective when given before meals, but supplemental insulin alone can be scheduled for patients who are not eating or are high risk for hypoglycemia.
- **Basal** insulin refers to a dose of long acting insulin given 1 or 2 times daily. These insulins absorb slowly to help maintain stable glucose levels.
- **Supplemental** insulin is dosed based on either weight or total daily insulin requirement.
- A **basal/bolus** insulin regimen uses both types of insulin to recreate a physiologic pattern of insulin release. This regimen is more effective for most patients than sliding scale supplemental insulin only. Most patients need about half of their insulin as basal and half as bolus. Patients on high doses of steroids will often need more bolus insulin.
APPENDIX C: Critical Care Insulin Infusion Transition

Note: This does NOT apply to patients with DKA, EDKA, or HHS (see Hyperglycemic Emergency Management (DKA/EDKA/HHS) – Adult algorithm)

Clinical judgement may supersede exact calculation of total daily dose if patient’s clinical status has rapidly changed during transition period.

Patient on ICU insulin infusion and meets ALL of the following criteria:
- Not in DKA/EDKA/HHS
- Maintained on insulin infusion ≥ 6 hours
- Controlled blood glucose (≥ 3 blood glucose < 180 mg/dL in past 6 hours)
- Steady insulin infusion doses for a minimum of 6 hours (not varying by > 2 units/hour)

Does patient meet any exclusion criteria?¹

- Continue insulin infusion and re-evaluate as clinically indicated
- Consider Endocrinology-Diabetes Consult for transitioning off of insulin infusion

Calculate estimated TDD of subcutaneous insulin by multiplying the average hourly insulin infusion dose from the previous 6 hours by 24 and then multiply by 0.8²,³

NPO or eating < 50% of meals

Eating ≥ 50% of meals or on intermittent enteral feedings

Continuous enteral feedings

Initiate basal insulin (glargine) subcutaneously with dose based on 50% TDD
- POC glucose checks every 6 hours
- Discontinue insulin infusion 2 hours after basal insulin administered
- Initiate supplemental sliding scale bolus insulin (regular) subcutaneous every 6 hours
  - TDD < 40 units: Low dose
  - TDD 40 - 80 units: Medium dose
  - TDD > 80 units: High dose

Initiate prandial sliding scale bolus insulin (lispro) subcutaneous using 50% of TDD divided into three pre meal doses

Initiate supplemental pre meal sliding scale bolus insulin (lispro) subcutaneous
  - TDD < 40 units: Low dose
  - TDD 40 - 80 units: Medium dose
  - TDD > 80 units: High dose

See Appendix D for basal/bolus insulin calculation tables

Note: This does NOT apply to patients with DKA, EDKA, or HHS (see Hyperglycemic Emergency Management (DKA/EDKA/HHS) – Adult algorithm)

Clinical judgement may supersede exact calculation of total daily dose if patient’s clinical status has rapidly changed during transition period.

Calculate estimated TDD of subcutaneous insulin by multiplying the average hourly insulin infusion dose from the previous 6 hours by 24 and then multiply by 0.8²,³

1 Exclusion criteria include: Currently receiving vasopressor therapy or parenteral nutrition (PN) or steroid dose fluctuating > 20% in the past 24 hours or insulin infusion dose > 5 units/hour or enteral feedings not at goal rate
2 Example: Average hourly infusion dose from the previous 6 hours = 3 units/hour; multiply by 24 = 72 units; multiply by 0.8 = 57.6 units, rounded up to 58 units = TDD; see Appendix D for basal/bolus insulin calculation tables
3 Consider decreasing the TDD by 20% for patients with renal dysfunction; Example: TDD = 58 units decreased by 20% = 46 units

Note: After transitioning off of insulin infusion, continue to evaluate glycemic control and adjust management as clinically indicated
APPENDIX D: Basal/Bolus Insulin Dosing Calculation Tables

**Note:** Clinical judgement may supersede exact calculation of total daily dose if patient’s clinical status has rapidly changed during transition period
- Consider dose reduction in patients with renal dysfunction

### NPO or Eating < 50% of Meals

<table>
<thead>
<tr>
<th>Average Hourly Dose of Insulin Infusion</th>
<th>First Dose of Basal Insulin (Glargine)</th>
<th>Maintenance Dose of Basal Insulin (Glargine)</th>
<th>Dose of Prandial (Pre-Meal) Scheduled Short/Rapid Acting</th>
<th>Regular Insulin Supplemental Sliding Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to 1 unit/hour</td>
<td>9 units once</td>
<td>5 units every 12 hours</td>
<td>-</td>
<td>Low dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>2 units/hour</td>
<td>19 units once</td>
<td>10 units every 12 hours</td>
<td>-</td>
<td>Low dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>3 units/hour</td>
<td>28 units once</td>
<td>14 units every 12 hours</td>
<td>-</td>
<td>Medium dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>4 units/hour</td>
<td>38 units once</td>
<td>19 units every 12 hours</td>
<td>-</td>
<td>Medium dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>5 units/hour</td>
<td>48 units once</td>
<td>24 units every 12 hours</td>
<td>-</td>
<td>High dose sliding scale every 6 hours</td>
</tr>
</tbody>
</table>

### Eating ≥ 50% of Meals or Intermittent Enteral Feedings

<table>
<thead>
<tr>
<th>Average Hourly Dose of Insulin Infusion</th>
<th>First Dose of Basal Insulin (Glargine)</th>
<th>Maintenance Dose of Basal Insulin (Glargine)</th>
<th>Dose of Prandial (Pre-Meal) Scheduled Lispro</th>
<th>Lispro Insulin Supplemental Sliding Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to 1 unit/hour</td>
<td>9 units once</td>
<td>5 units every 12 hours</td>
<td>3 units three times daily before meals</td>
<td>Low dose sliding scale three times daily before meals</td>
</tr>
<tr>
<td>2 units/hour</td>
<td>19 units once</td>
<td>10 units every 12 hours</td>
<td>6 units three times daily before meals</td>
<td>Low dose sliding scale three times daily before meals</td>
</tr>
<tr>
<td>3 units/hour</td>
<td>28 units once</td>
<td>14 units every 12 hours</td>
<td>9 units three times daily before meals</td>
<td>Medium dose sliding scale three times daily before meals</td>
</tr>
<tr>
<td>4 units/hour</td>
<td>38 units once</td>
<td>19 units every 12 hours</td>
<td>12 units three times daily before meals</td>
<td>Medium dose sliding scale three times daily before meals</td>
</tr>
<tr>
<td>5 units/hour</td>
<td>48 units once</td>
<td>24 units every 12 hours</td>
<td>16 units three times daily before meals</td>
<td>High dose sliding scale three times daily before meals</td>
</tr>
</tbody>
</table>

1. Maintenance dose of basal insulin (glargine) should start no sooner than 12 hours AFTER first dose. Hold for glucose < 120 mg/dL.
2. Hold for glucose < 100 mg/dL or if NPO.
**Continuous Enteral Feedings**

<table>
<thead>
<tr>
<th>Average Hourly Dose of Insulin Infusion</th>
<th>First Dose of Basal Insulin (Glargine)</th>
<th>Maintenance Dose of Basal Insulin (Glargine)</th>
<th>Dose of Scheduled Regular Insulin</th>
<th>Regular Insulin Supplemental Sliding Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to 1 unit/hour</td>
<td>9 units once</td>
<td>5 units every 12 hours</td>
<td>3 units every 6 hours</td>
<td>Low dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>2 units/hour</td>
<td>19 units once</td>
<td>10 units every 12 hours</td>
<td>4 units every 6 hours</td>
<td>Low dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>3 units/hour</td>
<td>28 units once</td>
<td>14 units every 12 hours</td>
<td>7 units every 6 hours</td>
<td>Medium dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>4 units/hour</td>
<td>38 units once</td>
<td>19 units every 12 hours</td>
<td>9 units every 6 hours</td>
<td>Medium dose sliding scale every 6 hours</td>
</tr>
<tr>
<td>5 units/hour</td>
<td>48 units once</td>
<td>24 units every 12 hours</td>
<td>12 units every 6 hours</td>
<td>High dose sliding scale every 6 hours</td>
</tr>
</tbody>
</table>

1 Maintenance dose of basal insulin (glargine) should start no sooner than 12 hours AFTER first dose. Hold for glucose < 120 mg/dL.
2 Hold for glucose < 100 mg/dL or if enteral feedings interrupted and notify ICU Team.

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**Notes:**
- Clinical judgement may supersede exact calculation of total daily dose if patient’s clinical status has rapidly changed during transition period.
- Consider dose reduction in patients with renal dysfunction.

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SUGGESTED READINGS


DEVELOPMENT CREDITS

This practice consensus statement is based on majority opinion of the Hyperglycemic Management experts at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

**Core Development Team Leads**
- Conor Best, MD (Endocrine Neoplasia and HD)
- Sonya Khan, MD (Endocrine Neoplasia and HD)
- Sonali Thosani, MD (Endocrine Neoplasia and HD)

**Workgroup Members**
- Veronica Brady, PhD, MSN, RN (Endocrine Neoplasia and HD)
- Vivian Crowder,MSN, APRN, FNP-C (Endocrine Neoplasia and HD)
- Lakeisha Day,DMSc, PA-C (Nocturnal Program)
- Carmen Escalante, MD (General Internal Medicine)
- Wendy Garcia, BS*
- Abigayle Harrington, BSN, RN (Nursing Post Anesthesia Care Unit)
- Michelle Horng, PharmD (Pharmacy Clinical Programs)
- Kwame Koom-Dadzie, MD (Hospital Medicine)
- Victor Lavis, MD (Endocrine Neoplasia and HD)
- Celia Levesque, MS, APRN, FNP, CNS-BC (Endocrine Neoplasia and HD)
- Sally Mathews, MSN, APRN (Hospital Medicine)
- Michael Tanner Moser, PharmD (Pharmacy Clinical Programs)
- Hadeel Sahar, MBBCH (Hospital Medicine)
- Jolyn Taylor, MD (Gynecological Oncology & Reproductive Medicine)
- Jeena Varghese, MD (Endocrine Neoplasia and HD)
- Sigi Varghese, MS, APRN (Endocrine Neoplasia and HD)
- Khanh Vu, MD (General Internal Medicine)
- Mary Lou Warren, DNP, APRN, CNS-CC*
- Jessica Williams, MS, PA-C (Endocrine Neoplasia and HD)
- Mara Wilson, MS, APRN (Endocrine Neoplasia and HD)

* Clinical Effectiveness Development Team